

Starting Date

**I-131 WHOLE-BODY IMAGING AND/OR RETENTION MEASUREMENT
RECORD OF TELEPHONE SCHEDULING**

Patient: _____ **Sex:** _____ **Birthdate:** _____

Referring Physician: _____ **Phone/Beeper:** _____

Pertinent History:

Study Type:
[Select one]

- Imaging after I-131 Therapy by Radiation Oncology**
Date of Imaging? _____ (Usually 3-5 days after dose)
 (Notify front desk and sign form. Do not complete rest of form.)
- Whole-body Imaging (5-mCi study)** (Complete rest of form.)
- Whole-body Imaging/Retention (5-mCi study)** (Complete rest of form.)
- Whole-body Retention Only (1-mCi study)** (Complete rest of form.)

Prior Contrast?

- Thyrogen Pretreatment**
- Withdrawal Type A (3 wks)**
- Withdrawal Type B (6 wks)**

- | | | |
|---|--|---|
| <ol style="list-style-type: none"> 1. Administer TSH on days 1 and 2 2. Administer I-131 on day 3 | <ol style="list-style-type: none"> 1. Discontinue all thyroid hormone. 2. Obtain TSH 16 days after stopping thyroid hormone 3. Administer I-131 if TSH \uparrow* | <ol style="list-style-type: none"> 1. Substitute T3 (Cytomel) for T4 (Synthroid) for 4 weeks 2. Discontinue all thyroid hormone for 2 weeks. 3. Obtain TSH 10 days after stopping T3. 4. Administer I-131 if TSH \uparrow* |
|---|--|---|

*The serum TSH should be $>30 \mu\text{U/mL}$. If not, the study should be postponed until an elevated TSH is documented upon repeat measurement.

TSH to be obtained? _____ **When?** _____ **Result?** _____

Is Patient Lactating or Breast Feeding? Yes No
[I-131 therapy should be delayed for several weeks postpartum or after cessation of breast feeding.]

Pregnancy Status?: Male Postmenopausal Female S/P Tubal Ligation/Hysterectomy
Beta-HCG to be obtained? _____ When? _____
[Pregnancy test should be obtained as close as possible (≤ 7 days) to date of I-131 administration.]

Date I-131 to be Given? _____ **Date of Imaging or Retention Study?** _____
[Usually 2 or 3 days after dose.]

Patient Disposition After Imaging: Home Referring Physician's Office

Front Desk Notified that Patient on Schedule? _____
[Do not schedule > 2 patients/day for imaging without approval of charge technologist.]

_____	_____ M.D.	_____ M.D.
Date	Scheduling Physician Signature	Staff Physician Co-signature